Welcome to Weirton Medical Center Blood and Cancer Center. As a new patient, please fill out the information below.

PATIENT NAME: ______ **MR#:** ______ **DATE:** ______ **DOB:** ______ **AGE:** ______

PATIENT MEDICAL HISTORY:
(ie cancer, anemia, hypertension, etc)

Previous Chemotherapy / Radiation: When?

Medications: (Including Vitamins / Herbal Supplements)

Name Dosage / Frequency Reason (ie blood pressure)

Previous Surgeries: When?

Allergies: Reaction:

Immunizations: ☐ Tetanus ☐ Influenza ☐ Pneumonia ☐ Meningococcus ☐ Other
Date: ______ ______ ______ ______ ______

SOCIAL HISTORY:
Marital Status: ______ Occupation:______ Religion:______
Use of Alcohol (Never, rarely, Moderate, Daily): ______
Use of Tobacco ☐ Never ☐ Previously, but quit ☐ Current Packs per day______ Years of smoking:____
Use of drugs ☐ Never Type/Frequency______
Do you feel that you or anyone in your household is being abused or is at risk for abuse, neglect or exploitation?
Yes_____ No______

FAMILY MEDICAL HISTORY:

	Age	Diseases	If Deceased, Cause of death
Father	____		
Mother	____		
Siblings	____		
	____		
	____		
Grandfather(M)	____		
Grandmother(M)	___		
Grandfather(P)	____		
Grandmother(P)	___		
Other	____		

DO YOU HAVE AN ADVANCED DIRECTIVE? ☐ Yes ☐ No If yes, please provide a copy.
DO YOU HAVE A DURABLE MEDICAL POWER OF ATTORNEY? ☐ Yes ☐ No If yes, please provide a copy.